DOCUMENT RESUME

ED 200 052 FL 012 243

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TITLE The Context of Medical Decision-Making: An Analysis of Practitioner/Patient Communication.
INSTITUTION Southwest Educational Development Lab., Austin, Tex.
PUB DATE Sep 80
NOTE 34p.; In its Working Papers in Sociolinguistics, Number 75.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Discourse Analysis; *Females; Gynecology; Interaction; *Medical Care Evaluation; Minority Groups; *Motivation Techniques; Nonverbal Communication; Oncology; *Physician Patient Relationship; Socioeconomic Influences; *Sociolinguistics; Verbal Communication

ABSTRACT

This paper examines how the exchange of information in medical interviews is organized, and how that organization produces and constrains the negotiation of treatment decisions. The analysis is drawn from the verbatim transcripts of audio-taped practitioner/patient communications, information gathered from medical files, and other ethnographic materials. Twenty-one women were followed during a two-year period in a paired set of outpatient clinics (Faculty and Community Reproductive Oncology Clinics) in a teaching hospital. The following factors were examined: (1) the strategic use of language by practitioners and patients to negotiate treatment decisions; and (2) how the negotiation is produced and constrained by the specific organizational context in which it occurs, the practical concerns of the participants, and the asymmetry of their relationship. The linking of three levels of analysis in this study led to the observation that poor, minority, or powerless women are likely to receive radical procedures, even when these are not mandated on medical grounds. (AMH)

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Working Papers in Sociolinguistics, No. 75.

ED2000052

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FL012243

Sociolinguistic Working Paper

NUMBER 75

September 1980

Southwest Educational Development Laboratory

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Austin, Texas

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THE CONTEXT OF MEDICAL DECISION-MAKING: AN ANALYSIS OF PRACTITIONER/ PATIENT COMMUNICATION

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This paper examines how the exchange of information in medical interviews is organized and how that organization produces and constrains the negotiation of treatment decisions. An analysis of the process of medical decision-making suggests that medical practitioners, because of their status, medical knowledge and technical skill, have the potential to act as gatekeepers--providing options to some that are denied to others. They have the medical knowledge which patients lack, and the potential to control patients' access to and understanding of it. This asymmetry in the practitioner/patient relationship combines with the practical concerns each brings into the examining room and consulting office and as a consequence influences therapeutic discourse, and the treatment decision reached.

The Background Context

The research was done in a University teaching hospital. Like most teaching hospitals, the delivery of health care was organized into inpatient and outpatient services. The outpatient services were further divided into two clinical systems. These clinical systems were organized around medical specialities. My research was done in a paired set of clinics in the department of Reproductive Medicine and the speciality of Oncology (cancer).

The organization and staffing of each clinic led to my calling them the "Faculty" and "Community Clinics." The Faculty Clinic was staffed by Professors of Reproductive Oncology and primarily accepted patients referred by other medical practitioners in the community. The Community Clinic was staffed by residents under the supervision of attending physicians and primarily accepted patients referred by social agencies or other clinics in the hospital's system of community clinics.

*Preparation of this paper was supported in part by a Grant-in-Aid from the Working Papers in Sociolinguistics Project.

Over the course of nearly two years, I followed 21 women with abnormal Pap smears referred to, diagnosed and treated in the Faculty and Community Clinics. I found that women with abnormal Pap smears referred to the Community Clinic were more likely to receive nonconservative treatment (i.e., to receive hysterectomies) than were women referred to the Faculty Clinic (cf. Fisher, 1979 a).

The sample population was assembled largely for practical reasons. My entry into the hospital had been facilitated by a staff physician who was a Gynecological Oncologist. Consequently, the population was defined as women with cancerous or precancerous problems in their reproductive systems. Since I was interested in patients' careers as well as the negotiation of treatment decisions, I followed patients longitudinally through the diagnosis/treatment/recovery process. Doctor/patient interactions were recorded on audio-tape. Early in my involvement with patients, I found that I was not prepared to deal with death on a daily basis; consequently, no patients with invasive disease were part of the sample population.

To document the organization of doctor/patient communication, I spent nearly two years as a participant observer. During the first thirteen months, I did informal interviews with staff physicians, attending physicians, residents, medical students, nursing staff and other support personnel. I attended lectures for residents, read patients' files, observed in consulting offices and examining rooms, and visited patients in the hospital to talk informally about what they were feeling. For the next eight months, I audio-taped the exchange of information between practitioners and patients.

The analysis in this paper is drawn from the verbatim transcripts of the audio-taped practitioner/patient communications, information gathered from medical files, and other ethnographic materials.[1] My background knowledge grew from impromptu interviews with practitioners, and was heightened by attending lectures with residents, studying the resident's training manual and reading appropriate sections of their gynecological texts.

To display how medical decisions were negotiated in practitioner/patient communications, I extended the analysis beyond the linguistic

boundaries of transcripts and blended verbatim linguistic data with other ethnographic data. It seems reasonable to say that neither practitioners nor patients say aloud all of the features that contribute to their decision-making. Patients rarely say aloud that they do not trust their medical practitioner or that they suspect them of trying to manipulate the situation. Similarly, neither staff doctors nor residents say aloud that patients look like poor women or they talk like uneducated women. They do not say that these factors contribute to their recommendation of a less conservative treatment. Neither doctors nor residents say aloud that a particular patient has all the children she needs because she is on welfare and cannot afford the children she already has. They do not say that hairy underarms and legs, asking too many questions or being too quiet, acting too passive or too aggressive, wanting children or not wanting children (or more children) contributes to the treatment recommended. Residents do not say aloud that they need surgery experience or that a particular patient is a good candidate for a hysterectomy (even though hysterectomy is not mandated on medical grounds). Yet, while not said aloud, my observations suggest that these factors (and others like them) contribute to the negotiation of treatment decisions.

The Medical Context

Women with abnormal Pap smears provided an ideal population for studying differential decision-making. Pap smears are preventative health measures. They are recommended for most women once a year as a screen for cervical cancer. The results of Pap smears traditionally come in five classes--class one is normal and class five is the most abnormal and may be indicative of invasive disease. Classes two, three and four represent a grey area between normal and invasive disease. They often indicate dysplasia--abnormal changes in cells that, while not cancerous, are believed to be precursors to cervical cancer. Pap smears in this grey area present medical practitioners with the widest latitude of decision-making. The medical task with abnormal cells is to make sure that the whole area of abnormal cells can be visualized so as to rule out the possibility of invasive disease. Once the extent of the lesion and the degree of abnormality have been determined, treatment decisions

revolve around two separate but interrelated issues: 1) to protect women from developing more extensive disease (cancer); and 2) to preserve, where possible, women's reproductive functions.

During the course of my study there were three treatment options routinely used to treat women with abnormal Pap smears in the middle range between normal and invasive disease. These were: cryo-surgery (freezing), cone biopsy or conization, and hysterectomy. Cryo-surgery is an office procedure which retains women's reproductive capacities. Cone biopsy, or conization is a hospital procedure done under anesthesia. A thin, cone-shaped slice is cored out of the endocervical canal and examined. Cone biopsies can be either a diagnostic or a therapeutic technique. If the upper limits of the cone sample are free of abnormal cells, then this diagnostic procedure becomes an effective therapeutic one. It threatens, but does not terminate, a woman's reproductive capacity and has been demonstrated to be as effective in treating dysplasia as hysterectomy. Hysterectomy is the surgical removal of the uterus.

The manual prepared for residents stipulates how treatment decisions are to be made. It stipulates that when the upper limits of the lesion are seen and there is no evidence of invasive disease, the treatment is predicated on patients' wishes. If they wish to retain their reproductive capacity, conservative measures like cryo-surgery may be utilized. If they request sterilization, hysterectomy is the treatment of choice. Hysterectomies are presented as: 1) only indicated where conservative techniques fail; 2) when there is evidence of invasive diseases; or 3) when patients request hysterectomies for sterilization.

These seem to be rather clear criteria for medical decision-making, yet, based on my observation, treatment decisions are not as clear-cut as they seem. On purely medical grounds, it is difficult to explain why no patients in the Faculty Clinic received hysterectomies, or, since there was no evidence of invasive disease, why seven out of thirteen women in the Community Clinic were hysterectomized. Given the parameters just outlined, it would be fair to speculate that the women in the Community Clinic requested hysterectomies for sterilization; however, I was in the examining room while treatment decisions were reached and none of the patients made any such request.

The Social Context

If treatment decisions are not made on medical grounds alone, how are they made? Much of the literature of medical sociology (cf. Mechanic, 1968; Freidson, 1970; Waitzkin and Waterman, 1974; Navarro, 1972; Stevens, 1966; Ehrenreich and Ehrenreich, 1970) suggests that medical decisions can be accounted for on the basis of social criteria. However, medical decision-making in this sample cannot be justified solely on social grounds. Social criteria such as referral patterns, organization of the setting, and demographic factors such as age, ethnicity, number of children and social class did not account for the distribution of treatment decisions. When social criteria are considered, a trend can be seen. Young, Caucasian, single or divorced women with few or no children, referred from private physicians or from social agencies to the Faculty Clinic are more likely to receive conservative treatment; while, older, Mexican or Mexican-American women, married or divorced with multiple children, referred from within the system of community clinics or from social agencies to the Community Clinic are more likely to receive less conservative treatment--e.g., to receive hysterectomies.

Borrowing the concepts of career and career contingencies (cf. Hughes, 1958; Becker, 1963; Goffman, 1961) I traced patients' progress from the medical setting in which their abnormal Pap smears were first discovered through their referral to either the Faculty or the Community Clinics and from there through diagnosis and treatment. When I did so, I found that there were career paths through which referrals were made, and these paths had consequences for treatment decisions. For example, all of the patients referred from within the system of community clinics stayed in that system while all of the patients referred from private practitioners were referred to the Faculty Clinic. Patients referred from social agencies went to both the Faculty and Community Clinics.

The referral of patients to the Faculty clinic was based on "Personal Professional Relationships." The referring medical practitioner had developed a personal relationship with the patient and could rely on a professional relationship with one of the staff oncologists at the hospital. Personal Professional referrals established a kind of external advocate. The referring medical practitioner was kept informed of the patient's diagnosis, treatment and prognosis and had the potential to hold the system accountable for patient care. However, the referral of

patients to the Community Clinic was not based on Personal Professional referrals. Instead, these referrals were organized by the interests of the medical bureaucracy and were managed in assembly line fashion. In this referral pattern there was no outside advocate to hold the system accountable. The bureaucratic equivalent of medical adequacy was applied--was the care adequate to handle the medical problem.

Once referred, the Faculty and Community Clinics provided very different settings in which to deliver and receive medical care. While they were organized around the same medical specialties, they were organized in different ways, to serve a different population of patients and were staffed in a different manner. The Faculty Clinic was staffed by a Gynecological Oncologist who was a professor of medicine. There were no residents rotating in and out of the clinic; thus, there was a continuity of care not normally found in teaching settings. The physical layout honored the humanness of patients. There was a separation of public and private space. The waiting room was separated from the back-stage medical area. Examining rooms were separated from consulting offices.

In comparison, assignment to the Community Clinic, the narrow definition of the medical problem under their care and the constant rotation increased the fragmentation of the care delivered. The Community Clinic was staffed by rotating residents, support personnel and supervisors, thus contributing to a lack of continuity of care. In addition, there was no separation of public and private space. There was no waiting room. Patients sat in the hall outside of the examining room overhearing medical talk that frightened them. Nor were there any consulting offices. All talk with patients occurred in the halls (in the presence of other patients) or in examining rooms. It is a very different experience to sit across the desk from a doctor while fully clothed, discussing your medical problems, than it is to have similar discussions with a resident while sitting undressed on the examining table.

While these social factors are important, they are not explanatory. An analysis of the medical and social factors which underlie treatment decisions focuses on the products of a decision. Once products, or treatment decisions are tabulated and grouped together, all instances of a given treatment decision are treated the same. This kind of analysis leaves

several questions unexplored. Chief among them are: 1) how do practitioners and patients gather information from each other to reach decisions; 2) given the practitioners' specialized medical knowledge and technical skill and the asymmetry inherent in the relationship, how do they convey information to patients and what are the consequences, in terms of treatment outcomes, of the ways in which information is exchanged. These questions shift the focus from an exclusive concern with products to an analysis of process. It displays treatment decisions as produced and constrained by the exchange of information in medical interviews.

The Analytic Context

When listening to conversation, one is impressed with the variety of ways that information is exchanged. When analyzing discourse, one is equally impressed with its organized character. The analysis in this paper draws from theories and research which examine the structural properties of talk and the importance of context for the analysis of discourse. While linguistic and sociolinguistic theories, the philosophy of ordinary language, theories of conversational or discourse analysis and ethnomethodology all show a concern for the structural properties of talk, they differ in their consideration (or lack of consideration) of context.

Concern for the structural properties of talk are evident in the work of early abstract linguists (cf. Chomsky, 1959, 1965). While conversational analysts (cf. Sacks, 1966, 1968; Schegloff, 1968; Sacks, Schegloff and Jefferson, 1974) extend the unit of analysis beyond the sentence and study naturally occurring talk, they too analyze components (e.g., turn allocations) and generate underlying rules to explain them. The philosophers of ordinary language (cf. Wittgenstein, 1953; Austin, 1962; Searle, 1969) provide the foundation to examine talk in its contextual environment by treating talk as accomplishing action, instead of indexing underlying rules. However, it is the work of sociolinguists, ethnomethodologists and discourse analysts which suggests that language is a social production in which different linguistic arrangements are visible in different situations. They propose that there is a relationship between the words spoken, the actions performed and the structure of the talk.

The sociolinguistic concepts of "communicative competence" and its methodological counterpart, an "ethnography of speaking" (Hymes, 1962, 1972, 1974), have been foundational to many studies which examine the properties of natural language use (cf. Bernstein, 1971; Labov, 1972; Shuy, 1970; Halliday and Hasan, 1976; Shatz and Gelman, 1973; Bauman and Sherzer, 1974; Philips, 1972; Ervin-Tripp and Mitchell-Kernan, 1977). Discourse has also been analyzed in institutional contexts. A preponderance of this research has been done in the classroom (cf. Sinclair and Coulthard 1975; Shuy and Griffin, 1978; Griffin and Humphrey, 1978; Mehan, 1979; Eder, 1979). However, there is a growing literature from other institutional contexts (cf. Corsaro, 1980 for a review of this literature).

Labov and Fanshel examine discourse in therapy situations and demonstrate Hymes' (1962) claim that discourse is a social or speech event organized around an exchange of information. As a speech event, therapeutic discourse is a routinized form of behavior with well defined boundaries. It is an interview structured by who initiates the event and who is helped by it. The speech event in therapeutic discourse was found to be asymmetrical; the participant who initiates the event and is helped by it (the client/patient) is in a subordinate position. In addition, they demonstrate that the asymmetry is socially produced and structures the exchange of information between participants.[2]

In discussing medical interviews Shuy (1979) suggests that a great deal hinges on small features of the interview which are normally taken for granted by medical practitioners and only recently have come under investigation by social scientists. He points out that medical interviews are like other conversations in that they are structured, predictable and organized around topics. He also demonstrates that medical interviews are different from normal conversations. In normal conversation there is an expectation of balanced participation. Participants talk, introduce topics and respond to topics in about the same quantities. This is not true in medical interviews. Shuy claims further that the differences in medical interviews have an impact on patients' participation and understanding. Others also argue that the ways in which information is exchanged is situationally produced (cf. Mehan, 1979; Shuy and Griffin, 1978) and has an impact on the ways it is understood (cf. Cicourel, 1975; Chafe, 1976; Keenan and Schieffelin, 1976; Kuno, 1976). The examinations of discourse in institutional contexts combine to suggest that talk in institutional contexts involves some of the same properties as talk in

more natural daily contexts, but utilizes them in ways that are context specific.

The analysis in this paper relies on studies which have examined the structure of talk and the importance of context for the analysis of discourse. It will: 1) examine the organization of practitioner/patient communication as a process occurring in the more specialized institutional context of a paired set of outpatient clinics (Faculty and Community Reproductive Oncology Clinics); 2) demonstrate that practitioner/patient communication is a speech event oriented toward the specific end of treatment decisions; and 3) display how language is used strategically by practitioners and patients to negotiate treatment decisions and how that negotiation is produced and constrained by the specific organizational context in which it occurs, the practical concerns of the participants and the asymmetry inherent in their relationship.

The Decision-Making Context: The Medical Interview

An analysis of the practitioner/patient communication through which treatment decisions are negotiated provides information not available in a consideration of the medical and social criteria underlying medical decision-making. These criteria are the external and constraining social facts which produce and inhibit the decision-making process. However, treatment decisions are also negotiated by the activities of the participants and as such are socially produced in the setting. An analysis of the strategic use of language in medical interviews displays how treatment decisions are negotiated within the contextual framework provided by medical and social factors. In this paper, for illustrative purposes, I will focus on the strategic use of language with the topics most central to the decision-making process (Cancer, Option and Reproduction Talk) and demonstrate how during medical interviews, treatment decisions are collaboratively accomplished in practitioner/patient communication.

Actors do "work" to exchange the information necessary to reach treatment decisions. When the topic is cancer or treatment options, practitioners initiate. Initiations take the form of providing information with patients in the response slot either providing or requesting additional information. When the topic is reproduction, practitioners initiate.

Initiations take the form of requesting information with patients in the response slot providing it.

The analysis of the strategic use of language suggests that practitioners have power which patients lack. This power is manifested and reflected in the ways in which practitioners present information to patients. While patients do not have the same kind of power, they too have input into the decision-making process. Patients can ask questions which hold the potential to redirect talk about treatment options and have consequences on the treatment decision reached.

The discussion of the ways in which language is used strategically takes the analysis beyond the linguistic bounds of the transcript and embeds it in its ethnographic context. A comparison across settings, participants, and treatment decisions provides a view of how treatment decisions are negotiated and accomplished in the situated actions of the participants and in specific organizational contexts, thus placing linguistic phenomena in their social context and providing the basis from which to analyze how the context organizes linguistic structures.

Strategic Use of Language

Medical interviews are social events oriented toward the specific end of a treatment decision. In this event, language is used strategically to accomplish treatment decisions. Practitioners, because of their specialized knowledge and technical skill, act as gatekeepers in the decision-making process. They have and use quite a latitude of choice in recommending among the available treatment options. In analyzing how language is used strategically to accomplish treatment decisions, I do not intend to characterize the field of medicine as a whole or criticize particular medical practitioners. Rather, it is my intention to demonstrate that medical practitioners and patients have different practical concerns, which organize the ways they exchange information and this organization has consequences in terms of the decision reached.

Patients enter medical interactions from positions of relative weakness. They have an abnormal Pap smear and feel threatened by the possibility of a cancer-related medical problem. They enter unfamiliar surroundings in which all of the other participants seem to share a common language. This language is for the most part, unintelligible and frightening to them.

Medical practitioners, on the other hand, are in their "home courts" in the medical setting. They understand and have some control over the workings of the hospital and clinic bureaucracies. The specialized jargon of medical talk is their professional lexicon. They have knowledge and skills which are basically mysterious to patients. It is from this position of relative strength that practitioners greet patients and the medical interview begins.

Medical practitioners, in addition, are very busy. Their time is budgeted and oriented toward making a diagnosis and recommending treatments. For practitioners the diagnostic/treatment process is a generalized concern. Their focus is on how, within certain parameters, to best treat a specific medical problem. The patient is one among many with similar problems. For residents, the diagnostic/treatment process includes an additional concern. Residents need surgery experience if they are to become competent doctors. This need for surgery experience creates a dual focus for them: 1) providing medically adequate care and; 2) producing maximum opportunities for surgery experience.

The practical concerns are not the same for patients. They are not interested in making a diagnosis, cannot recommend treatments and do not need surgery experience. Time is not the same kind of constraint for them. It is not measured into equal increments to be divided among a maximum number of patients; the focus is on the meaning of their medical problem and its impact on their daily lives. Time is measured as time away from school, work or family; time until they find out the results of laboratory test or treatments to be recommended; time as a bomb ticking away precious moments before the expected cancer explodes and takes over their lives. They are interested in finding out what their abnormal Pap smears mean, whether they are indicative of cancer and what needs to be done about them. They are afraid of the unknown, worried about having cancer, and fearful that their lives, reproductive capacities and value as women may be in jeopardy (Fisher, 1979b).

Both practitioner and patient have information necessary to the decision-making process of the other. To gain access to this information, they exchange data organized around topics by requesting and providing information to each other. During the exchange, language functions strategically to move the decision-making process closer to the accomplishment of a treatment decision. On some occasions requests for information function as "Questioning Strategies." They both request specific information

and provide access to less specific information. For example, the question--What did Karen tell you about your abnormal Pap smear?--is a request for specific information.[3] It is also a way to gain less specific information about the woman's competence as a patient. Both practitioners and patients use Questioning Strategies. Practitioners use them in Reproduction Talk to gain access to information which only patients can supply. Patients use them during Option Talk to gather information about the necessity of the treatment being recommended.

On other occasions, information is provided in ways that function as "Presentational" and "Persuasional Strategies." Both of these strategies are selling mechanisms. They provide information while at the same time suggesting or specifying how it should be understood. Presentational Strategies are "soft sells." They provide information while suggesting how patients should make sense out of it. For example, the presentation--we usually treat this by freezing--provides the patient with information about a treatment option while suggesting that it is the "usual" or "normal" way to treat her condition. Persuasional Strategies are harder sells. They provide information while specifying how it should be understood. For example, the presentation--What you should do if you don't want any more children is have a hysterectomy. No more uterus, no more cancer, no more babies, no more birth control and no more periods--provides the patient with information about what treatment option she should have while specifying why she should have it (no more uterus, no more cancer, etc.).

Only practitioners use Presentational and Persuasional Strategies. They use these strategies when talking about cancer and treatment options to provide information about the treatment decision the patient should make. Questioning, Presentational and Persuasional Strategies are interaction mechanisms which accomplish treatment decisions. They are strategies through which the information necessary to negotiate treatment decisions is exchanged.

The Communicational Context: The Negotiation of Treatment Decisions

To demonstrate how language is used strategically to accomplish treatment decisions, I will examine the ways in which doctors and patients use questions and the ways in which practitioners present information.

Medical Practitioners' Use of Questioning Strategies

Questioning Strategies provide a slot for patients to display their competence. For example in one case, the patient, Marrianna, was diagnosed and treated in the Faculty Clinic. She is a 21-year-old Anglo woman, a student at a local university, has never married, has no children, has been pregnant once and had an abortion. She was referred to the Junior Oncologist in the Faculty Clinic by a Women's Health Care Specialist. The treatment of her abnormal Pap smear is in interesting ways related to her earlier abortion. Raised as the adopted daughter of a Catholic family, she was unable to make the decision to use contraception. Since she met, "fell in love" with a young college man, and became sexually active, it is no surprise that she became pregnant. Nor is it a surprise that she was sufficiently embarrassed not to go to her family physician or to use the medical facilities provided by her university. Instead, she went to a Women's Health Care Specialist for abortion counseling, birth control consulting and all future reproductive related matters. A routine Pap smear taken in this clinic was returned with the notation that it contained abnormal cells and because of the professional relationship between this Women's Health Care Specialist and the new doctor in the hospital (the Junior Staff Oncologist) she was referred to the Faculty Clinic.

On her first visit during an exchange of information talk in the doctor's consulting office, the questions that he asked allowed her to display her competence. The doctor twice requested information that functioned strategically. He said: "Now did Karen explain to you the abnormal, what this abnormal Pap smear business is?"[4] And he said: "Dysplasia, what's your understanding of that?" In both of these requests for information, Marrianna responded by providing the information requested. In answer to the first question, she said: ". . . she (the Women's Health Care Specialist) explained that the cells look abnormal . . . the cells are in a dysplastic condition." In answer to the doctor's second question, she responded: "Well, what's anyone's understanding of it? They're abnormal and you don't know why and they don't know if it leads to cancer." Her replies both provided the specific information requested and displayed her as a competent young woman (see fig. 1, Appendix).

In the next case, the same doctor asked similar questions, but the patient did not display herself as competent. This case was also diagnosed

and treated in the Faculty Clinic. The patient, Anelen, is a 30-year-old Anglo woman. She has been married once, divorced, been pregnant once and given the child up for adoption. She was referred to the same Junior Staff Oncologist by the same Women's Health Care Specialist. On her first visit, she spent just a short while in the consulting office talking to the doctor. She was a soft-spoken, shy woman; during this exchange of information she did not display her competence as a patient. She did, however, display herself as a counter-culture woman. She had unshaven legs and underarms, wore no makeup and dressed in counter-culture style.

During the interview the doctor asked a question that functioned strategically. He said: "Do you know that the Pap smear, do you understand what that Pap smear means? What it does?" The patient responded by saying: "Uhm, Karen explained a little, but I'm not sure of the possibilities. I don't even know what all those are but she told me not to worry yet." This response neither provided the information requested nor displayed the patient as a competent woman. To be sure that she had the necessary information to understand her medical problem and reach a decision, the doctor followed this exchange by providing information about her Pap smear and about the diagnostic and therapeutic procedures used to manage it (fig.2).

In this next case, no slot was provided for the patient to display her competence. This case was diagnosed and treated in the Community Clinic. The patient, Marvi, is a 23-year-old Mexican-American woman. She is married, the mother of three small children, and was referred to the Community Clinic from the Primary Care Clinic where a post-partum check and routine Pap smear disclosed abnormal cells on her cervix.

The diagnosis and treatment of Marvi's Pap smear are related in interesting ways to her reproductive history, the economic reality of her life and the bureaucratic organization of the system of community clinics. Marvi displayed herself as a poor woman unable to afford any more children and as an incompetent birth control user. At the time of her visit to the Community Clinic she had an unwanted pregnancy which led to an abortion. While this was her first abortion, it was not her first birth control failure. Given these factors, it is not surprising that a hysterectomy was recommended. What is more surprising is the fact that she did not receive one. She is the only woman in the sample population with multiple children who did not want more children and who was treated with cryo-surgery.

It was the bureaucratic organization of the system of community clinics that contributed to her treatment with cryo-surgery. A tubal ligation for sterilization was discouraged and a hysterectomy was recommended in the Community Clinic both to treat her medical problem and for sterilization. When the patient was referred to another clinic for abortion counseling, that clinic had no such aversion to a tubal ligation. The patient was given an abortion and a tubal. When she returned to the Community Clinic, there were no longer any medical grounds upon which to perform a hysterectomy and she was treated with cryo-surgery.

During the initial exchange of information the resident asks no questions. Instead, he provides information to the patient. He explains the result of her laboratory tests, their relationship to cancer and the need for treatment. However, when talking about the patient's reproductive history and desire for additional children, he does ask questions. The patient's responses display her as incompetent in the use of birth control (fig.3).

The exchange of information in this case is very different than in the last two (Marrianna and Anelen). Since no questions were asked during the initial exchange of information, the patient does not have a chance to display her understanding of her medical problem or her competence as a patient. When the resident does ask questions during the discussion of reproduction, Marvi displays herself as an incompetent user of birth control. It is interesting to speculate on why the resident uses no questions to gather more information. I suspect that he had already judged her to be incompetent on grounds that are not displayed in the verbal communication between them. This assumption then structured the exchange of information which followed.

Patients' Use of Questioning Strategies

Patients too ask questions. They ask them in response to information provided by medical professionals during a discussion of treatment options. Questions when used by patients have the potential to change the direction of the treatment decision. The patient's use of questions in the following two cases does just that.

When Anelen returned to the Faculty Clinic to discuss the results of her tests and make a treatment decision, she asked a question during a discussion of treatment options. On her prior visit in response to the information that she did not want to have any more children, the doctor

recommended a hysterectomy as a permanent method of sterilization and as treatment for her abnormal Pap smear.

On the second visit the exchange opens with a discussion reviewing what had transpired on the prior visit and during a prior phone conversation. This exchange ends with a question about the patient's desire to be sterilized. The patient, in response, provides her understanding of the information they have already exchanged and a discussion of treatment options begins. The doctor reminds her that he recommended a hysterectomy. The patient asks a question redirecting the talk about treatment options. This has a consequence on the treatment performed. She says: "Have a hysterectomy and that, I'm that, if there's an alternative. I'm terrified of operations." The discussion of treatment options continues with the doctor's presentation of alternatives. He begins this presentation by saying: "Uh, okay, well, there certainly is an alternative, yeah, we can treat this by just freezing it here in the office and that usually will take care of it about 90 per cent of the time." The discussion of options and the treatment performed are redirected after the patient raises a question. She was treated with cryo-surgery (fig.4).

In the next case the patient's introduction of a question also changes the direction of the discussion of options and the treatment decision. The patient, Lucy, was diagnosed and treated in the Faculty Clinic after being referred from a social agency staffed by native Spanish speakers. She is a 42-year-old bilingual Mexican-American woman. She is married and has three children. In interesting ways her diagnosis and treatment in the Faculty Clinic are related to her being a poor, bilingual, Mexican-American woman, and to my participation as both a researcher and translator.

The patient had a medical problem which sent her to her private physician. He recommended surgery and she did not have the money to pay for it. In her search for less expensive medical care, a friend referred her to the outreach clinic staffed by native Spanish speakers. In this clinic, she both received advice about how to apply for MediCal[5] and was referred to the Junior Staff Oncologist at the Faculty Clinic.

When the doctor and patient met to discuss treatment options, he informed her that the extent of her lesion had not been visualized, told her that she needed to have conization biopsy as the next diagnostic step, and talked about a hysterectomy. The patient was concerned and confused. She was

concerned about how she would pay for hospital care and confused by the letter she had received from MediCal. She asked the doctor to clarify the letter. He was unable to do so.[6] In order to provide the information that she requested, he called the billing office. While he was on the phone, the patient turned to me and asked in Spanish if the doctor had said he was going to take out her uterus. Since I speak Spanish (during my two years in the hospital I routinely translated for medical practitioners and patients) I explained the difference between a conization biopsy and a hysterectomy and confirmed that the doctor had been talking about removing her uterus. She asked me if that would be necessary and I suggested that she ask the doctor.

Two things particularly struck me about our exchange. First, since she spoke English so well, both the doctor and I assumed that she understood it equally well. She did not. In looking over the transcript, I was not surprised. When talking about treatments, the doctor used several words interchangeably: womb, uterus, cervix, and hysterectomy. I was also struck by the consequences of our exchange. At the next opportunity, which occurred during a discussion of treatment options, the patient requested information that functioned strategically. This strategy changed the direction of the discussion of options and had a consequence on the treatment performed.

While talking about how long the patient would be hospitalized, the doctor explained that a longer stay was necessary because they would be taking out her uterus. The patient then asked: "Is that necessary?" The doctor responded by saying: "Well, it isn't absolutely necessary; it may or it may not be . . ." For much of the remaining exchange of information, the doctor worked to move the patient towards a treatment decision of hysterectomy. In each instance the patient responded by asking if it was necessary or by saying that if it was not necessary, she did not want it. She was treated with a conization biopsy (fig.5).

Another patient, Pat, asked questions but did not change the direction of the discussion of options or the treatment performed. Pat is a 32-year-old Anglo woman. She has been married, divorced, pregnant five times, and has three children. While she is an American citizen, she married and has lived most of her adult life in Ireland--her children still live there with their father. When she returned to the Community Clinic to discuss her treatment

options, she was told the extent of the lesion had not been visualized, asked if she wanted more children, and told that a conization biopsy followed by a hysterectomy was the best treatment for her.

During the discussion of treatment options and in response to information the resident was presenting, she made a request for information that functioned strategically. She said: "Well, for this way now would you say, for instance, you're talking about there could be surgery if, uh, there is an advancement of cancer there, a sign of cancer. Well, also, the fact that you asked me did I want any more children, there's another way of doing it too, but it also means that it could travel, is that it, the cancer could spread, say, for instance, if I don't have a hysterectomy, is that the idea?" The doctor responded by saying: "Well, if you have cancer, then it has to be treated because it can spread, right." The talk about treatment options does not change the direction of the Option Talk or the treatment performed. This patient was treated with a vaginal hysterectomy (fig.6).

The communication between practitioner and patient is different in this case than in the prior two (Anelen and Lucy). Pat is the only patient who added information to the "facts" provided by the medical practitioner. She added the notion that cancer could spread if not treated with a hysterectomy. It was this information which the resident picked up and used to justify his treatment recommendation. Pat's question is not as clear or strong as those used by the prior two patients (Anelen and Lucy). She did not ask if there were other alternatives or if a hysterectomy was necessary. In addition, she asked two questions during the same utterance. The resident avoided the first entirely. He did not address whether there were alternative treatments. And he only answered part of the second. He did not address whether it (the abnormal cells) would spread if she did not have a hysterectomy. Instead, he answered a hypothetical question that she had not really asked. He answered the question if it is cancer, would it spread without a hysterectomy. He did not tell her that if she did not have cancer, there were other alternatives.

In Anelen's, Lucy's, and Pat's cases, the medical professional's presentation of information provided a slot into which the patient could request information that functioned strategically. In each case the medical professional's response to the question was different. In addition, the medical professionals elicited information from patients differently in each case.

With Anelen the doctor asked questions to request specific information and to provide a slot for her to display her competence. In response she neither provided the information nor displayed her competence. In the case of Lucy and Pat, no questions were asked. Neither patient was given an opportunity to display her understanding of her medical problem or her competence as a patient.

Medical Practitioners' Use of Presentational and Persuasional Strategies

While both practitioners and patients ask questions, doctors do so during exchanges of general information and to gather the details of patients' reproductive history and desire. Patients, by contrast, ask questions during discussions about treatment options. In addition, there are differences in the ways medical practitioners present information to patients when discussing cancer and treatment options. They use Presentational and Persuasional Strategies to provide patients with the information necessary to reach treatment decisions and with ways of understanding or making sense out of that information.

In each of the above three cases the medical professionals' response to patient's questions provided specific information and suggested how that information should be understood. In Anelen's case the doctor responded by saying: "There certainly is an alternative . . ." and by providing the information that cryo-surgery is an alternative that is 90 percent effective. He both provided specific information and by the tone of his presentation made the choice of cryo-surgery perfectly acceptable. In Lucy's case the doctor responded by saying: "Well, it isn't absolutely necessary . . ." The statement that "it isn't absolutely necessary" frames the medical information suggesting a preference--while a hysterectomy is not absolutely necessary, it certainly is preferable. In Pat's case the resident avoided answering the patient's question directly. By answering only a small part of what was asked, he suggested that the answers to the whole were contained within the part; that is, that a hysterectomy was a necessary procedure.

In Lucy's and Pat's cases the medical practitioner used Presentational Strategies to suggest how information should be understood. In the next case information is presented in a way that does more than suggest how to make sense out of it. Persuasional Strategies are used to specify the

grounds upon which understanding is to be based. In presenting the options to Marvi, the resident said:

> ". . . what I was going to tell you is that there are two ways this can be treated. Okay. One is for dysplasia that we could do a hysterectomy and just remove the uterus. That means no more babies in the future and so you know, as a form of contraception also, okay. The second is to freeze the cervix and then follow you with the understanding that that should cure it, but that you need to be followed in the future and that you could have children in the future if that's what your plans include."

The ways in which the resident presented the information about a hysterectomy as a way not to have any more babies in the future and as a method of contraception had persuasive overtones. To a woman with an unwanted pregnancy, and who has had repeated birth control failures, this is a particularly persuasive presentation. This is a poor woman who does not want more children and has neither the time nor the money to return to the hospital for frequent follow-up care. In addition, the presentation of a hysterectomy first, prior to the presentation of cryo-surgery, functioned persuasively. It suggested that the less conservative treatment (hysterectomy) is somehow preferable. Later on in the exchange the resident sums up his position using another Persuasional Strategy. He said: absent uterus, no periods, no cancer, no babies . . ." (fig.7).

Similarly, in Pat's case, when the resident presented her with an informed consent form to sign, he said:

> "Even though with this form that I have before that the government requires you to sign, it's a request for a hysterectomy for sterilization, even though it says here that you have no problems which require a hysterectomy, and we know that you do, the hospital and the state require me to ask you to sign this so that you understand that what we're talking about is permanent sterilization with no possibilities of future pregnancies."

This is a particularly persuasive presentation. The patient did not, in any way, request a hysterectomy for sterilization. She had been referred to the clinic with a class five Pap smear. During the discussion about treatment options, a hysterectomy was recommended as the most appropriate treatment. The grounds for this recommendation were specified as ". . . it (cancer) could come back . . ." and ". . . for somebody your age, that's had your family, you're sure that you don't want children, I'd recommend a hysterectomy." To a woman who has had a class five Pap smear and is afraid that she has a life-threatening medical problem, this is a particularly

persuasive presentation. It heightens the emotional impact of the abnormal Pap smear by stressing the possibility that "it" could come back. In addition, it is the resident not the patient who links the need for a hysterectomy with the patient's age, her prior childbearing history and her lack of desire for additional children. To a woman who has lived many of her childbearing years in a Catholic country and has had three children and two abortions, this again is a very persuasive presentation. The persuasive overtones were further magnified when the resident presented the informed consent form for her to sign and told her that while the form said she had no problems which required a hysterectomy, " . . . we know that you do." He brings all of the authority of his medical role to bear in this statement. As a man, as a medical practitioner and as her doctor, he is telling her what to do and implying dire consequences if she does not comply.

There is an additional issue involved in this presentation. The resident told the patient what he was required to by law and then suggested that she ignore it. Again evidenced is the power and authority of his medical role and his use of it to manipulate the patient's decision-making process. One might ask, what kind of informed consent procedure this represents.

Both Presentational and Persuasional Strategies are used by practitioners when discussing cancer and treatment options. Practitioners, because of their specialized knowledge and technical skill, have information which patients need to reach their decisions. In addition, through the strategic use of language during the medical interviews, practitioners can control patients' access to and understanding of that information.

The Communicational Event: Reaching a Treatment Decision

The data discussed in this paper suggest that the medical interview is structured and organized in predictable ways. The structure of medical interviews reflects the asymmetry in the practitioner/patient relationship, the differential impact of the setting as well as the different, and sometimes conflicting, interests of the participants. While both practitioners and patients need information from the other to reach treatment decisions, it is medical practitioners who most often control the topic under discussion and access to the floor. While patients do not have the same kind of power that doctors do, they too have impact on the decision-making process. They can, and do at times, ask questions which hold the potential to redirect

talk about treatment options and the treatment performed. While both practitioners and patients ask questions, only practitioners use Presentational and Persuasional Strategies. While hysterectomies are recommended by both doctors and residents in the Faculty and Community Clinics, only residents in the Community Clinic performed them.

A detailed analysis of the medical interview through which information is exchanged and treatment decisions are negotiated provides information not available in an analysis of the medical and social facts underlying medical decision-making. It displays the process through which treatment decisions are jointly accomplished. First, medical practitioners and patients, exchanging the information necessary to reach treatment decisions, use language strategically, thus doing communicational work. In addition to specifying how treatment decisions are negotiated in the activities of participants, this kind of analysis suggests that the communicational work of participants is oriented toward the specific end of a treatment decision; thus linking interaction (or communication) with outcomes (or treatment decisions). Finally, this kind of analysis places the decision-making process in a specific organizational context.

By placing linguistic phenomena in their social context and analyzing how that context organizes linguistic structures, three levels of analysis (structural, organizational and interactional) which are normally treated separately are linked. The detailed analysis of the communicational process through which treatment decisions are negotiated displays how when patients are poor, minority or powerless women, hysterectomies are more likely to be performed even when they are not mandated on medical grounds. The negotiation of treatment decisions is thus produced and constrained by structural, organizational and interactional contexts and accomplished by the activities of the participants.

There are theoretical, methodological and practical ramifications inherent in the documentation of the communication work through which treatment decisions are reached. Theoretically and methodologically, a systematic analysis of the communicational strategies used to accomplish treatment decisions provides insights not normally available when the subtleties of the practitioner/patient relationship are not examined. These insights can have practical consequences for medical education, resident training and the creation of informed consumers. In an era in which both medical practitioners

and patients are displaying increasing dissatisfaction with the way things are--the high cost of medical care, the increasing performance of unnecessary medical procedures, the difficulties with patient compliance, the problems of informed consent, and the increasing use and possible abuse of medical malpractice procedures--awareness of the processes used to communicate hold the potential for improving communication and improving the delivery of health care.

APPENDIX

FIGURE 1: Medical Professional's Use of Questioning Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
faculty clinic; first visit in consulting office (P dressed in street clothes)	Marrianna	information	D	And you had an abnormal Pap smear back in February which she treated and then repeated. Now, did K explain to you the abnormal, what this abnormal Pap smear business is?	I	P	Well, uhm, in February when I had a Class 2, uhm, she explained the cells looked abnormal// and so we treated it with AVC cream and, uh, I was away from San Diego for awhile and when I came back, I thought I was fine because the reason I had gone in the first place was because I had a discharge and it was strong smelling. It wasn't itching or anything and so I never had these symptoms again and when I went back, we had another Pap smear and I was sure I was fine and then she called me and told me it was Class 3 this time and she said even if it had been Class 2 again, we would probably go through the same procedure. But a Class 3, the cells are in a dysplastic condition.	IP	D	Uh hum	Displayed her competence

FIGURE 1 (Cont'd)

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
			D	Dysplastic, what is your understanding of that?	IR	P	Well, what's anyone's understanding of it? They're abnormal and you don't know why and they don't know if it leads to cancer//	IP			treated with cryo-surgery

FIGURE 2: Medical Professional's Use of Questioning Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
faculty clinic: first visit in consulting office.(P dressed in street clothes)	Analen	Information	D	Uh, do you know what the Pap smear, do you understand what the Pap smear means, what it does?	IR	P	Uh, K explained a little bit, I'm not sure of the possibilities. I don't even know what all these are but she told me not to worry yet.	IP			Does not display her competence as a patient.
same visit in examining room (P on examining table)		Reproduction	D	You probably have a little precancerous condition here but, uh, do you want any more children?	IR	P	No.	IP			Provided the information requested and the grounds upon which the D could recommend a hysterectomy
			D	You don't want any more children?	IR	P	No, I asked K to mention that I was considering a tubal//	IP			

FIGURE 3: Medical Professional's Use of Questioning Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
Community clinic examining room (P dressed in street clothes)	Marvi	Information	D	And, now, let's explain to you what the results showed, okay? You understand what happened last time? That last time we looked at your cervix//with a					P	Uh hum, yeah	No slot provided for P to display her competence
				microscope//and took					P	Uh hum	
				biopsies//of all those areas that appeared abnormal//okay? Now the					P	Uh hum	
				areas that appeared abnormal came back with what we call dysplasia, okay? Now what does that mean? That's a big word that means that the					P	Uh hum	
				cells were not normal// Now that certainly is not cancer but we know that if, if we didn't treat this,// that it's					P	Uh hum	
				the kind of thing that given five to ten years// might turn into cancer so we think it needs to be treated. Now the					P	It might, cancer	
				question is, you're 23// and you have three children//					P	Uh hum	
				correct?	IR	P	Uh hum.	IP	P	Uh hum	

FIGURE 3 (Cont'd)

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
	Marvi	reproduction	D	What are you using for birth control now?	IR	P	Well, I was using douching and using the foam. I, well, wasn't on birth control pills.	IP	D	Okay	Displays herself as incompetent reproducer and later as a woman who wants no more children.
			D	But you're using something for birth control.	IR	P	Yeah.	IP			
			D	Do you know that douching does not, is not// a contraceptive, no.	IR	P	I know, I don't think so, that's what I came to see the doctor again because I'm behind on my period two months.	IP	P	No.	
			D	...that you could have children in the future if that's what your plans include.	IP	P	That's what I don't want. I don't want//	IP			

FIGURE 4: Patient's Use of Questioning Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
Faculty clinic consulting office (P dressed in street clothes). Subsequent visit.	Anelen	Information	D	What did we, I talked to you on the phone, didn't I? About your Pap smear or not, about your biopsies, or not? (reading from file)	IR	P	Yeah, yeah.	IP			Redirects talk about treatment options from talk about hysterectomy back to talk about cryo-surgery
			D	I told you that you had, uhm, some abnormal cells there. And, uh, that we needed to do something about the ones that are still there. And you said you wanted to be sterilized, is that right?	IR	P	Well, I was thinking of having a tubal// but you had told me last time I was here that you wouldn't advise a tubal. If I wanted to go that route//		D	Uh huh	
		Option	D	Have a hysterectomy.	IP	P	Have a hysterectomy and that, I'm, that if there's an alternative, I'm terrified of operations.	IR			
			D	Uh, okay,well, there certainly is an alternative, yeah, we can treat this by just freezing it here in the office and that usually will take care of it about 90% of the time.//					P	Uh hum	
			D	We may have to freeze it a couple of times but usually it will take care of the problem. So you want us to do that?	IR	P	Uh, yeah.	IP			treated with cryo-surgery

FIGURE 5: Patient's Use of Questioning Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
Faculty clinic. Subsequent visit to discuss treatment options--in consulting office (P dressed in street clothes)	Lucy	ability to pay	D	Now, uh,//since it would be, uh, it's going to be each month, you're probably going to have, you know// $234 that you'll be responsible for, the best thing to do would be to do all of your surgery at once,//do the small biopsy one day and the hysterectomy the next. Understand what I mean //so that all the bills//	IP				P	Uhm	Changed the direction of option talk and had consequences in terms of the treatment performed
									P	Yes	
									P	Uh hum	
						P	Would I have to stay in the hospital two days then?	IR	P	Uh hum	
			D	You'd have to stay in about a week or more.	IP	P	In the hospital?	IR			
			D	Yeah, because we would take the uterus out,see	IP	P	Is that necessary to take it out?	IR			
		reproduction	D	Well, it isn't absolutely necessary, it may or it may not be, I don't know until we do this first, the first test,if the first test removes all of the precancerous cells.	IP						treated with conization biopsy

FIGURE 6: Patient's Use of Questioning Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
Community clinic in examining room. Subsequent visit to discuss treatment options (P dressed in street clothes)	Pat	option	D	//...the precancerous condition can be treated by just having a hysterectomy, whereas, uh,//	IP						Didn't change the direction of option talk or the treatment recommended.
						P	Well, for this way now would you say, for instance, you're talking about there could be surgery if, uh, there is an advancement of cancer there, a sign of cancer, well, also the fact that you asked me did I want any more children, there's another way of doing it too, but it also means that it could travel, is that it, the cancer could spread, say for instance, if I don't have a hysterectomy, is that the idea?	IR			
			D	Well, if you have cancer, then it has to be treated, because it can spread, right?	IP	P	Yeah, so no matter which way it goes, some part will be removed?	IR			
			D	Uh, no, not necessarily. It can be treated by radiation treatments only.//					P	I see.	treated with hysterectomy

FIGURE 6: (Cont'd)

Setting	Patient	Kind of Talk	Speaker	Initiation	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
	P.t	option	D	...Even though with this form that I have before me that the government requires you to sign, it's a request for a hysterectomy or for sterilization, even though it says here that you have no problem which requires hysterectomy, and we know that you do, the hospital and state require me to ask you to sign this.							

FIGURE 7: Medical Professional's Use of Persuasional Strategies

Setting	Patient	Kind of Talk	Speaker	Initiation Act	Language Function	Speaker	Response Act	Language Function	Speaker	Comment Act	Outcome
Community clinic examining room (P dressed in street clothes)	Marvi	option	D	Well, I don't know if I'm ready, ready to treat you at the present time. Well, what I was going to tell you is that there are two ways this can be treated, okay? One is for dysplasia that we could do a hysterectomy and just remove the uterus.// That means no babies in the future//and so, you know, as a form of contraception also, okay. The second is to freeze the cervix//and then follow you with the understanding that that should cure it but that you need to be followed in the future and that you could have children in the future if that's what your plans include.	IP	P	That's what I don't want. I don't want//	IP	P	Uhm	P was referred for abortion counseling; had a tubal ligation, returned to the Community Clinic and was treated with cryo-surgery.
									P	Uh hum	
									P	Uh hum	
			D	Absent uterus, no periods//no cancer, no babies. Sounds like you'd rather have your cervix frozen.	IR	P	Yeah, I think so.	IP	P	Uh hum	

Footnotes

1. I use quotation marks to differentiate two kinds of linguistic data. When field notes provide the basis for the talk being discussed, no quotation marks are used. By contrast, I use quotation marks to indicate that the talk being discussed is taken directly from verbatim transcripts of audiotapes. In addition the interaction is displayed in the coded transcripts which are also provided. In these transcripts, IP, IR and // stand for information provided, information requested and overlaps or interruptions respectively. The interactions in the transcripts are displayed as "adjacency pairs" (Sacks, 1966). This display is based on several assumptions. First, initiations are acts which demand responses. Second, on some occasions and in some settings initiation/response pairs are followed by option third pair-parts--i.e., comment acts. And finally, the third pair-part reflects and displays the asymmetry in the patient/practitioner relationship (cf. Griffin and Humphrey, 1978; Mehan, 1979; Fisher, 1979a).

2. The asymmetry in the therapist/client relationship discussed by Labov and Fanshel (1977) is similar to the "competence gap" described by Waitzkin and Waterman (1974). Waitzkin and Waterman claim that doctors and patients, due to the socioeconomic realities of the society in which they live, come to the therapeutic interview with different resources. They suggest further that these differences produce an inherent asymmetry which has consequences in terms of the delivery of health care (cf. Fisher, 1979a, for a fuller discussion of this point).

3. When no quotation marks are used, the language is demonstrative rather than verbatim.

4. The quotation marks used here indicate that this material was taken from verbatim transcripts of doctor/patient communication. The section of transcript being discussed is displayed in the first figure.

5. MediCal is the California equivalent of the Federal Medicaid Program.

6. This does not speak well for the clarity and simplicity of the communicational style of MediCal.

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